

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

**62-000751**

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

AMENDED

Registration District No.

Primary Registration District No.

Registrar's No.

**FILED JAN 31 1962**

1. PLACE OF DEATH a. COUNTY <b>Clay</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Clay</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Excelsior Springs</b>			Length of stay in 1b <b>years</b>		c. CITY OR TOWN <b>Excelsior Springs</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Spa-View Rest Home</b>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS <b>214 E. Excelsior</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Mattie</b> Middle <b>Jane</b> Last <b>Flack</b>				4. DATE OF DEATH Month <b>Jan.</b> Day <b>11,</b> Year <b>1962</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>3-20-1885</b>	9. AGE (last birthday) <b>76</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (City and state or country) <b>Ray County, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>James Coons</b>		13b. MOTHER'S MAIDEN NAME <b>Sidney Jane Taylor</b>		14. NAME OF HUSBAND OR WIFE <b>Van Flack</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>[REDACTED]</b>		17. INFORMANT Address <b>214 E. Excelsior</b> <b>Henry Coons, Excelsior Springs, Mo.</b>			
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. <b>Generalized arteriosclerosis</b> DUE TO (b) <b>15 yrs</b> DUE TO (c) <b>yrs</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Cerebral thrombosis &amp; Rt hemiplegia 6 wks</b>						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)			
20c. TIME OF INJURY Hour <b>a.m.</b> Month, Day, Year							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY	STATE
21. I attended the deceased from <b>Oct. 1954</b> to <b>11 Jan 1962</b> and last saw her alive on <b>10 Jan '62</b> Death occurred at <b>6:55 p.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <b>George E. Sanders M.D.</b>				22b. ADDRESS <b>Excelsior Springs, Mo.</b>		22c. DATE SIGNED <b>1-15-62</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>1-13-62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Salem</b>		23d. LOCATION (City, town, or county) <b>Excelsior Springs, Mo.</b>		(State)	
24. FUNERAL DIRECTOR <b>Prichard Funeral Home, Inc.</b> <b>Excelsior Springs, Missouri</b>		25. DATE RECD. BY LOCAL REG. <b>1-20-62</b>		26. REGISTRAR'S SIGNATURE <b>Caroline Hutchings</b>			

(Licensed Embalmer's Statement on Reverse Side)

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

INSTEAD OF

DATE AMENDED

BY AFFIDAVIT OF

DOCUMENT

MEDICAL CERTIFICATION

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed

*Lindell Jarman*

Licensed Embalmer No. *4589*

P. O. Address *Excelsior Springs, Mo.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.